

Aligning Provider Compensation to Create Value

Tips for optimizing compensation in the new value-based environment.

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As the health care system migrates to value-based reimbursed care, compensation plans will undoubtedly follow. The design of a compensation plan that incentivizes value-based care delivery should consider the alignment of program strategy and performance objectives. This article reviews the current state of cardiovascular health care compensation trends and offers recommendations for successful provider compensation planning as the industry moves forward.

COMPENSATION OVERVIEW: WHERE WE ARE NOW

Each year, MedAxiom conducts a survey of its membership, collecting more than 600 cardiovascular measures from both practices and hospitals. As part of this survey, compensation and production data are collected; this year, data from more than 3,000 cardiologists were included. In addition to tracking these data by subspecialty type, MedAxiom also collects the physician/group ownership model. "Private" indicates a physician-owned practice, with "integrated" meaning that the physician/group is part of a hospital or health system. For this latter model, the integration can be in the form of either employment or a professional services agreement.

As seen in Figure 1, compensation for interventional cardiology has remained relatively flat during the past 4 years, with only private physicians posting increases in each of the 4 years. Median compensation for interventional physicians in 2015 was \$600,018 per full-time equivalent (FTE)—up from \$563,485 in the previous year. Just like the other cardiology subspecialties, interventional physicians who integrated into a hospital or health system fare substantially better than their private peers in terms of total compensation. This delta topped \$100,000 per year in 2015, with integrated physicians earning \$621,469, compared to \$517,587 for private doctors—a 20% differential.

It is worth noting that, as in years past, interventional physicians are the highest paid of the cardiology subspe-

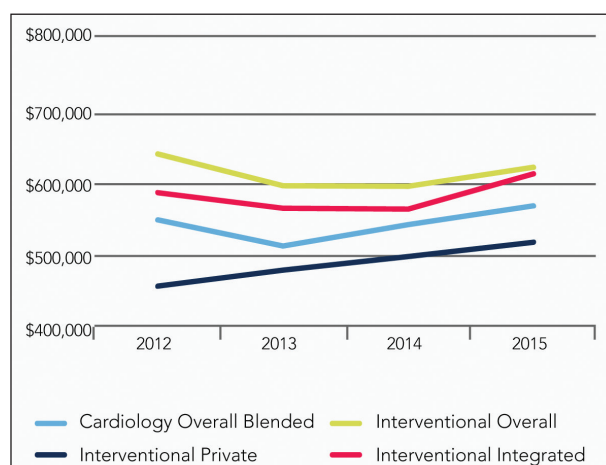


Figure 1. Total compensation by year.

cialties. The 2015 median compensation of \$600,018 was more than \$21,000 higher than the electrophysiology median compensation, the second ranking subspecialty. This top ranking for interventional physicians holds true, regardless of ownership model. Table 1 details compensation by subspecialty and ownership model.

Although integrated interventional cardiologists out-earned their private peers, they did so on 14% fewer work relative value units (wRVUs), as shown in Table 2. Interventional cardiologists in an integrated model produced 10,024 wRVUs per FTE, whereas private interventionists produced 11,385 wRVUs per FTE. The overall median production for interventional cardiologists was 10,258 wRVUs, second only to electrophysiology in terms of median wRVUs produced. Like compensation, wRVU production for interventional physicians is flat at best and possibly even declining (Figure 2). In both ownership models, reported 2015 median production is below the level reported in 2012, despite a slight recovery from 2014.

Table 3 shows compensation per wRVU. It is important to note that this rate is calculated by taking median com-

pensation and dividing it by median wRVU production. It should not be confused with a “conversion factor,” a rate per wRVU often designed into hospital physician employment agreements. Interventional physicians in 2015 earned \$60 per wRVU, the second highest rate per wRVU behind noninvasive physicians.

COMPENSATION PLANS SKEW TO PRODUCTION

In the last integration survey of its membership, MedAxiom found that > 60% of integrated cardiology compensation plans were based on wRVU production. There are multiple factors that drive this, but certainly one is that reimbursement still tracks very closely with wRVU

production, and the majority of cardiology still predominantly operates in a fee-for-service environment. In addition, hospitals and health systems find safety in the wRVU model, given that it is actually named in the Stark Law as an appropriate measuring stick for physician production. Likewise, valuation firms heavily rely on the wRVU for measuring production when rendering fair market opinions on hospital integration models for similar reasons. The wRVU only measures a physician's professional and personal contribution to care, so he or she has no ties to a referral.

Another strong reason for supporting wRVUs is that the system attempts to normalize production across all medical specialties (and does a pretty good job of it), including between cardiology subspecialties. This makes it ideal for measuring work differences from peer to peer and partner to partner, particularly when work is a component of internal distribution plans. Work RVUs are also the most often used productivity measure for cardiologists, in either employment model, when individual physician production is used to determine individual compensation. In 2015, 41% of cardiology practices employed a production-based compensation plan internally (Figure 3). By contrast, 18% utilized an equal-split model.

Hospitals continue to remember the integration wave in the early 1990s, during which, physician practices were acquired, and compensation favored guaranteed salaries. Not altogether surprising in these conversions, physician production tended to fall, sometimes precipitously. This hang-over experience still drives an affinity to production-based compensation arrangements. Unlike the 1990s, in which the threat of managed care was a crystal ball prediction, today's integration wave—particularly for cardiology—is driven by real economic changes. First, reimbursement for imaging services decreased nearly 40% from 2003 to 2008. Second, value-based reimbursement is not a prediction, it is the law.

TABLE 1. TOTAL COMPENSATION BY SUBSPECIALTY AND OWNERSHIP MODEL

Integrated	25th Percentile	Median	75th Percentile
General noninvasive	\$361,899	\$510,026	\$616,388
Invasive	\$470,845	\$582,829	\$703,409
Interventional	\$502,367	\$621,469	\$741,255
Electrophysiology	\$498,186	\$600,237	\$741,501
Private	25th Percentile	Median	75th Percentile
General noninvasive	\$268,658	\$413,660	\$560,847
Invasive	\$294,880	\$489,054	\$707,314
Interventional	\$339,732	\$517,587	\$728,446
Electrophysiology	\$384,198	\$498,303	\$656,289
Overall	25th Percentile	Median	75th Percentile
General noninvasive	\$350,441	\$495,192	\$616,495
Invasive	\$442,916	\$580,676	\$706,348
Interventional	\$467,110	\$600,018	\$740,811
Electrophysiology	\$456,565	\$577,756	\$725,482

TABLE 2. WORK RELATIVE VALUE UNITS BY SUBSPECIALTY AND OWNERSHIP MODEL

Integrated	25th Percentile	Median	75th Percentile
General noninvasive	5,865	7,825	9,895
Invasive	7,289	9,573	11,888
Interventional	7,844	10,024	12,616
Electrophysiology	8,771	11,530	15,074
Private	25th Percentile	Median	75th Percentile
General noninvasive	6,799	9,952	12,805
Invasive	5,602	8,202	10,391
Interventional	9,057	11,385	14,837
Electrophysiology	10,048	13,327	16,148
Overall	25th Percentile	Median	75th Percentile
General noninvasive	6,083	8,046	10,380
Invasive	7,062	9,374	11,670
Interventional	8,186	10,528	13,022
Electrophysiology	9,152	11,741	15,677

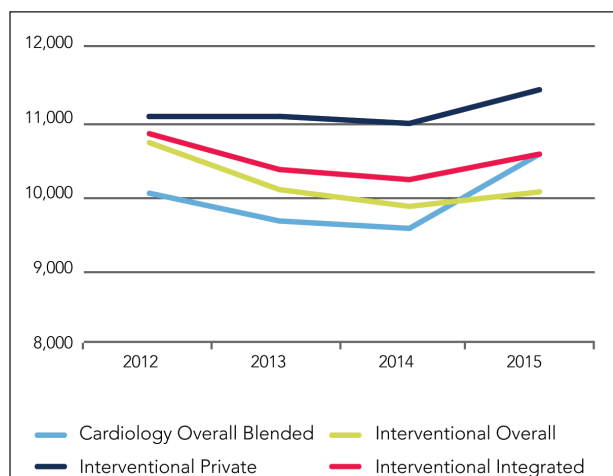


Figure 2. Median production by year.

ALIGNING INCENTIVES

For all the good the wRVU has in its favor, it is steeped in a fee-for-service world. As its name implies, the wRVU measures work, but not the quality of that work or if what was produced was even necessary in the first place. The Centers for Medicare & Medicaid Services is quickly moving reimbursement away from total adherence to volume indicators and introducing significant risk for value (outcomes, cost, and satisfaction). Value-based purchasing is an example of this in the hospital setting, with the Medicare Access & CHIP Reauthorization Act of 2015 (also known as MACRA) being an example on the professional side.¹

TABLE 3. COMPENSATION PER WORK RELATIVE VALUE UNIT			
Integrated	25th Percentile	Median	75th Percentile
General noninvasive	\$61.70	\$65.18	\$62.29
Invasive	\$64.60	\$60.88	\$59.17
Interventional	\$64.04	\$62.00	\$58.76
Electrophysiology	\$56.80	\$52.06	\$49.19
Private	25th Percentile	Median	75th Percentile
General noninvasive	\$39.51	\$41.57	\$43.80
Invasive	\$52.64	\$59.63	\$68.07
Interventional	\$37.51	\$45.46	\$49.10
Electrophysiology	\$38.24	\$37.39	\$40.64
Overall	25th Percentile	Median	75th Percentile
General noninvasive	\$57.61	\$61.55	\$59.39
Invasive	\$62.72	\$61.95	\$60.53
Interventional	\$57.06	\$56.99	\$56.89
Electrophysiology	\$49.89	\$49.21	\$46.28

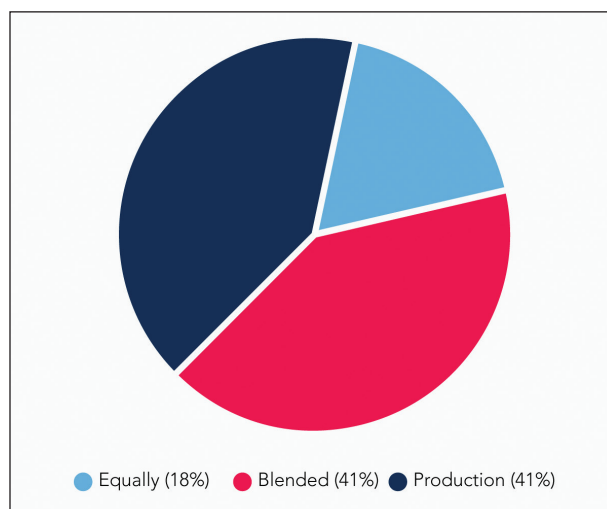


Figure 3. Compensation plan internal distribution method: 18% equal-split, 41% blended, and 41% production-based.

Production-based employment agreements do not necessarily sync well with a value economy and, in fact, can create disincentives. Consider interventional services—these life-saving procedures can provide dramatic value to patients and health systems. However, sometimes the best course of treatment is noninvasive or deciding to do nothing at all. If this is the case, physicians are actually punished (in terms of compensation) for doing the right thing when their compensation is driven predominantly on production measures. This is just one example, but there are myriad others.

Likewise, as hospitals and health systems attempt to retool their infrastructures to be successful in the new value world, they desperately need physicians actively engaged in the process. This work often requires substantial investments of physician time in order to achieve results. If this time is expected to be “donated,” which is effectively the case with production-based compensation, history proves that physicians will resist or curtail involvement. This should not come as a surprise. It is simply a matter of recognizing what is being valued—in the case of production-based compensation, this is at the exclusion of everything else.

In response to the misaligned incentives, hospitals and health systems are beginning to introduce value into their employed compensation plans or relationships with private groups. This may take the form of formal comanagement arrangements or simply be via incentive compensation. Beginning in 2014, MedAxiom began collecting nonclinical compensation data from its membership, which are summarized in Table 4. They show

**TABLE 4. NONCLINICAL MEDIAN COMPENSATION/
FULL-TIME EQUIVALENT**

	2014	2015
Leadership positions	\$6,667	\$9,632
Medical directorships	\$11,869	\$8,481
Hospital/health system incentives earned	\$22,046	\$23,090
Hospital/health system incentives available	\$30,000	\$41,667
Total nonclinical compensation earned	\$45,457	\$45,464

that value-based incentive compensation is substantial (\$45,464 per physician total earned), with hospital incentives making up the largest component (\$41,667 per physician available). It is also noteworthy that these incentives are not from “softball” measures, given that just \$23,090 of the \$45,464 available per physician (55%) was actually earned.

CREATING VALUE, TRANSLATED

Traditionally, a cardiologist creates value for patients by caring for them while they are ill. A cardiologist creates value for hospitals and health systems by providing services for patients within the hospital facilities, performing perfunctory medical staff tasks, and clinically advancing the service offering. Although the provision of these services is still considered valuable, today's priorities and expectations require additional and different value-adding activities. Simply put, creating value today means providing the services, but has the additional metrics of providing services with proven quality that is patient satisfying and justified in cost. It is commonly believed that the key components of providing value-based care require astute attention to care processes, adherence to evidence-based medicine, and processes to support the same. To provide value-based care, clinicians are required to create clinical consensus as well as discover and eliminate unnecessary care and outcome variation. All of these activities require significant physician involvement, and none of these activities is measured in wRVUs.

When considering cardiovascular program value, it is important to examine the program's subspecialized nature. Contemporary cardiovascular programs include cardiologists who provide general diagnostic and medical cardiology and cardiologists who specialize in imaging, interventional cardiology, heart failure, electrophysiology, structural cardiology, cardiac oncology, and preventive cardiology care. Cardiologists provide value in subspecialized programs by pursuing continued training and expanding their own and their program's clinical capabilities with subspecialized contemporary therapies and treatments. The subspecialized approach to clinical care is paired with subspecialized delivery and, by nature, the requirement to collaborate and coordinate care. Subspecialization also results in a geometric

expansion of the work to standardize, measure, improve quality, and reduce variation in care. Subspecialized care also requires differentiated access to care in growing consolidated markets. Measuring sticks of value in today's environment include traditional measures of quality, cost, and satisfaction, as well as access, time to treatment, reduction of avoidable costs such as readmission, appropriateness, and degree of variation. By nature, the subspecialization of cardiovascular care in a value-based environment requires significant clinical and delivery redesign—work that requires significant physician effort and is not designated with wRVUs.

NEW COMPENSATION MODELS

Traditional compensation models that associate compensation with the production of wRVUs fall short in incentivizing the behaviors and activities required to deliver value-based care. Forward-thinking programs are redesigning compensation frameworks to better incent the full gamut of outcomes. Although design variation is significant, programs designing compensation frameworks to compensate for value are focusing on four basic elements: the job description and base compensation, an understanding of physician time allocation, alignment of incentives with delivery objectives, and the inclusion of incentive-based compensation.

First, contemporary programs are moving toward compensation designs that establish a base salary plus additional compensation for incentives. The base salary is accompanied with a job description that describes the full scope of the physician employee's responsibilities. Most importantly, the job description includes nonclinical care deliverables in addition to the more traditional clinical responsibilities. Base pay is often anchored to minimal production requirements to ensure a sense of good business practices, as well as to achieve legal approval and fair market value designation.

Second, programs that understand the importance of physician involvement in redesigning care systems and comanaging cardiovascular service lines, pursuing quality metrics, reducing care and outcome variation, and other nonproduction metrics, understand that achieving these outcomes will certainly require a physician's time. In some cases, physician time allowance is via involvement in specific service line roles or medical staff positions, such as contemporary medical director roles. In other cases, understanding of physician time requirements allows physicians to schedule improvement teamwork or other collaborative activities during a normal workday. Regardless of the how the time is recognized and schedule coordination is achieved, the physician-driven work is valued, and time is allowed to perform the work. It is not unusual for compliance purposes that documentation of the activities or physician time is required.

The third important consideration of designing a compensation framework that results in the delivery of value-based care is ensuring that incentivized activities are not

in conflict with delivery objectives. A seemingly obvious consideration, it is not uncommon for compensation plans to be in conflict with the objectives that the health system is attempting to achieve. Contemporary delivery models often involve multiple inputs from multiple providers and staff; they often utilize nontraditional delivery modalities and are designed to create easy access to services. Compensation plans that do not support the delivery design will be a barrier to its implementation. As an example, consider this care team objective: a cardiovascular program has a heart failure specialist managing advanced heart failure patients with the assistance of an Advanced Practice Provider (APP)–staffed heart failure clinic. If the heart failure cardiologist's base pay production threshold is not adjusted for the inclusion of APPs in the delivery system, the heart failure physician may be disincentivized to optimize the heart failure clinic capacity. In this circumstance, access may be restricted, and the APP expense may not be justified, thus the objective is not achieved. Careful consideration of all plan components is important to ensure the alignment of delivery objectives.

Finally, in order to create alignment with program objectives, compensation plans commonly include compensation opportunities for the achievement of performance objectives. Incentive pay is typically established as a percentage of the base pay or an established dollar amount. Compensation is typically paid for the physician group's success in established objectives, but it can be established at the physician level. It is not uncommon for incentive plans to include both group and individual physician goals. Incentive compensation often falls into five categories:

(1) quality, (2) efficiency, (3) patient satisfaction, (4) operations, and (5) program development. Most incentive programs include metrics from several categories and several subspecialties. Quality objectives are matched with core measures, government and payer incentive programs, and registry metrics. Quality measures may also include the adoption of contemporary practices (radial cath lab utilization) or the adoption of care protocols and standards. Efficiency objectives are often based on reducing cost variation, adoption of supply standards, staffing utilization, and other similar measures. Operations objectives may include measures involving timeliness of start times or discharge, timeliness of test interpretations, or implementation of a chest pain protocol. Program development objectives would include objectives such as establishing an atrial fibrillation clinic, opening a new outreach site, or other program advancement. Most incentive plans establish a base measurement, a threshold goal, and an aggressive or reach goal. Typically, each goal is individually incentivized, and on average, physicians achieve 80% of the incentive compensation opportunity. Matching goals to program objectives with a mix of metrics in several categories allows programs to align strategy and performance.

KEEP IN MIND

- Physician job descriptions should include both clinical and nonclinical responsibilities.
- The time required to perform nonclinical responsibilities should be considered in designing job description specifications and scheduling.
- Incentives should be aligned with the cardiovascular service line strategy and performance objectives.
- Baseline measurements should be established for every incentive, and measurement methodologies should be established.

LEGAL CONSIDERATIONS

The development of compensation frameworks involving incentive pay and consideration for nonclinical physician time compensation are made complex due to various legal compliance issues. Careful attention to legal compliance and the involvement of legal and valuation professionals is a wise compliance strategy. It is typical to involve health care attorneys in the development of plans and also common for the plan to be evaluated by a third-party valuation professional. Involving legal and valuation services is a common and logical compliance practice that protects both health systems and physicians.

CONCLUSION

It is important to remember that while value-based compensation plans typically do involve productivity requirements, productivity without regard to appropriateness and clinical quality, as well as compliance issues, will not position programs for successful performance under value-based reimbursement. ■

1. Centers for Medicare & Medicaid Services. The Merit-Based Incentive Payment System (MIPS) & Alternative Payment Models (APMs): delivery system reform, Medicare payment reform, & the MACRA. <http://go.cms.gov/1LHY4Fg>. Accessed April 21, 2016.

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